Communicating bad news

Ms Roberts, a 54-year-old African American woman with cirrhosis due to hepatitis B, presented with a new right upper quadrant abdominal pain. A computed tomographic scan showed a poorly defined mass with indistinct borders located near the portal vein. The likely diagnosis was hepatocellular carcinoma, probably unresectable due to proximity to the portal vein. A gastroenterologist tells her that the mass may represent cancer but that a liver biopsy is needed to establish the diagnosis. She agrees to the biopsy. Her physician reads the biopsy report while Ms Roberts is sitting in a clinic examining room.

What is the best way for the physician to handle the disclosure of this news with Ms Roberts? In this article, we review the empiric research that can guide physicians in communicating bad news.

METHODS

We performed a MEDLINE search using the index terms *communication* and *bad news* and screened the resulting 633 citations for relevance. We targeted citations based on empiric research. Additional literature was elicited from two excellent reviews.[1,2]

How do patients and physicians experience the delivery of bad news?

A useful definition of bad news is that it "results in a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received."[1] Thus, the determination of what news is bad constitutes a subjective judgment in the mind of the receiver, so when physicians assume they are delivering bad news, they may influence patients' responses.

Patients report a variety of emotional reactions to hearing bad news. In a study of patients who were diagnosed as having cancer, the most frequent responses were shock (54%), fright (46%), acceptance (40%), sadness (24%), and "not worried" (15%).[3] In addition, patient confusion can be an important contributor to distress commonly seen after a bad news discussion. The biggest source of patient misunderstanding is technical language. For example, in a study of 100 women with a diagnosis of breast cancer, there was substantial misunderstanding of prognostic and survival information, with 73% not understanding the term "median" survival when it was used by their physician.[4] Furthermore, they did not agree on the numeric equivalent of a "good" chance of survival.

Physicians are inaccurate at detecting patient distress during bad news encounters, and this may worsen patients' experiences. In an intensive qualitative study of five oncologists, only one of the five was able to reliably assess patient distress resulting from bad news. In other words, physicians' ability to accurately assess anxiety or depression related to a bad news consultation was no better than chance.[5] These findings contrasted with the physicians' self-assessment of their own performance: they rated their performance favorably and were highly satisfied with it.[6]

Many physicians experience intense emotions of their own when they communicate bad news to a patient. Ptacek and Eberhardt proposed a model of the stress associated with bad news that relates the physician's experience to that of the patient (Figure).[1] This model describes the physician's anticipatory stress before delivering bad news and suggests that physicians' stress peaks during the clinical encounter, whereas the patients' stress peaks some time afterward. This stress model can help physicians anticipate the challenges involved in communicating bad news, and some aspects of it have been empirically verified. In a large survey of oncologists, 20% reported anxiety and strong emotions when they had to tell a patient that her condition would lead to death.[7] In a more detailed study of 73 physicians, 31 (42%) indicated that, while the stress often peaks during the encounter, the stress from a bad news encounter can last for hours to 3 or more days afterwards.[8]

How competent are physicians at communicating bad news?

When asked to rate overall physician performance, patients are generally positive, but they also report that their needs and preferences are not always met during bad news discussions. Among 148 patients with breast cancer or melanoma, about 60% reported that their physicians'

Summary points

- Patients report a wide variety of reactions to bad news
- Physicians are unable to accurately detect patient distress in bad news encounters
- Many physicians experience intense emotions when they communicate bad news
- Patients desire a balance of sensitivity and honesty when receiving bad news
- Physicians should be alert to cultural preferences that limit disclosure

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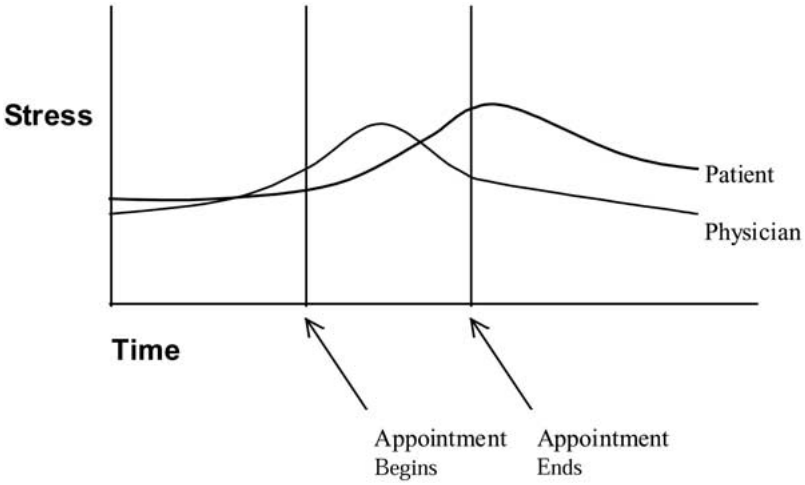

Stress experienced by physician and patient in the discussion of bad news (from Ptacek and Eberhardt[1]).

communication about bad news was "excellent" or "good," but 22% also reported that their physicians seemed nervous or uncomfortable.[3] Gaps between patients' needs and physician performance are particularly apparent when patients are asked whether physicians discussed the implications of the bad news. In a study of cancer disclosure experiences, only 14% of patients thought that diagnostic disclosure is the most important aspect of a bad news discussion; many patients thought that prognosis (52% of patients) and treatment (18% of patients) were more important. In the patients with breast cancer or melanoma, 57% wanted to discuss life expectancy, although only 27% of physicians actually did.[3] Most of these patients (63%) wanted to discuss the effects of cancer on other aspects of life, yet only 35% reported having these discussions. In another study, patients reported rarely receiving prognostic information.[9]

Qualitative studies characterize how physician competence in delivering bad news can fall short. A qualitative study of 79 patients with chronic and terminal illnesses, along with 68 family members and health care workers, found that two important factors made for good communication of bad news. The first was a willingness to talk about dying, and the second was disclosing bad news sensitively.[10] Poor delivery of bad news stemmed from being too blunt, discussing bad news at a time and place not appropriate for a serious conversation, and conveying the sense that there was no hope. Also, patients discussed the need for physicians to maintain a balance between sensitivity and honesty in discussing prognosis.[11]

Studies that examined the quality of physician competence in discussing do-not-resuscitate orders and prognosis, issues that may follow bad news, characterize other shortcomings. In an audiotape study of physicians discussing do-not-resuscitate orders with hospitalized patients, physicians spent 75% of the time talking and missed opportunities to allow patients to discuss their personal values and goals.[12] In a study of physicians' communication of prognosis, physicians reported that even if patients with cancer requested survival estimates, they would provide a frank estimate only 37% of the time and would provide no estimate, a conscious overestimate, or a conscious underestimate most of the time (63%).[9] Taken together, these studies suggest that physician competence at communicating bad news is suboptimal.

How should physicians communicate bad news?

Most American patients want to have straightforward, honest discussions with their physicians.[13] They also want their physicians to be sensitive in these conversations, and they value hope.[11] Some of these patients, however, want basic rather than extensive information.[14] In addition, patients and physicians identify a variety of barriers to discussing bad news, and individuals differ on their relative importance.[15] Thus, an approach to communicating bad news that encourages physicians to respond to the needs of individual patients may be more successful than a standardized script, although no comparative evaluations of bad news protocols have been reported.

Several recommendations on communicating bad news were endorsed by a multidisciplinary panel of experts and also rated as "essential" or "desirable" by more than 70% of 100 patients with cancer.[2] Many of these are found in published protocols for communicating bad news,[16-18] and they are summarized in the Table.

No one way is best to discuss different aspects of prognosis because patients differ in how they want to hear the news. For instance, among women treated for breast cancer, there was no consensus on whether they preferred a positively framed message (eg, 43% preferred discussing "chance of cure") or negatively framed message (eg, 33%

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Most patients want honest informative discussions about their prognosis

*A step-by-step protocol for communicating bad news**

Step	Description
Prepare for the encounter	If possible, have advance discussion with patient about who will be present Find a location with adequate privacy Arrange adequate time for discussion Review the clinical information
Assess the patient's understanding	Introduce everyone present Assess the patient's understanding of the situation Find out how much patient wants to know
Discuss the news	Provide information honestly and in simple language Tailor amount of medical details and technical language to patient wishes
Respond to the patient's emotions	Encourage patients to express their emotions Acknowledge the patient's emotions and empathize Tolerate silence
Offer to discuss implications of the news, including	Prognosis Treatment options Effect on quality of life Assistance talking to others Identify support services
Summarize the discussion	Restate important points Ask if there are any other questions
Arrange a follow-up time for patient and family questions and concerns	
Document the discussion in the medical record	

*From Girgis and Sanson-Fisher,[2] Baile et al,[16] Buckman and Baile,[17] and von Gunten et al.[18]

preferred discussing "chance of relapse").[4] Physicians need to inquire whether their communication is satisfying the patient's needs and be ready to reframe information.

Recall aids can assist physicians in giving bad news. Audiotapes of the patient-physician consultation have been shown to improve recall of important information and to reduce anxiety in some patients.[19] These audiotapes are typically listened to four to six times after the visit, often by family members or friends who were not present. Similarly, written summaries have also been shown to improve recall of important information, but patients tend to prefer audiotapes.[19]

Does competence in delivering bad news make a difference to patients?

Physician competence in delivering bad news influences patient adjustment to illness, anxiety, depression, hope, and decision making. In a study of 100 patients with breast cancer surveyed 6 months after surgery, adjustment to illness correlated with physician behavior during the cancer diagnostic interview and with the patient's history of psychiatric problems and premorbid life stressors.[20] Interestingly, the study's findings indicate that the physician's caring attitude was more important than the information provided during the clinical encounter. In another study, patients who perceived that the provision of information was handled poorly during an initial cancer consultation were twice as likely to be depressed or anxious than patients who were satisfied.[21] Patients who have concerns that have not been addressed are also more likely to be depressed.[22]

Bad news discussions also influence patient hope. In a descriptive study, 56 patients recently diagnosed as having cancer reported that physicians contributed to their hope in a variety of ways and that giving information in a sensitive way increased hope.[23] However, because of concern about damaging hope, both patients and physicians may collude to avoid talking about difficult information.[24] Similarly, in a study of patients with advanced AIDS, physicians reported that fear of destroying a patient's hope is one of the most common and important barriers to discussing end-of-life care.[15]

The link between the communication of bad news and patients' subsequent treatment decisions is not entirely clear. However, in a study of patients with cancer who were seriously ill, those who unrealistically overestimated their survival were more likely to choose life-prolonging therapy and to die in the hospital after attempted cardiopulmonary resuscitation or mechanical ventilation.[25] This study emphasizes the effect of inaccurate patient understanding and suggests that improved communication about bad news may influence patients' choices about life-sustaining treatments.

How do cultural differences influence communication of bad news?

Patients of different ethnic backgrounds vary in their preferences about how to hear about bad news such as a cancer diagnosis. In a study involving European, African, Mexican, and Korean Americans, Blackhall and colleagues demonstrated a wide variation in patients' willingness to discuss a diagnosis of metastatic cancer openly.[26] Many of these families address the issue indirectly by focusing on practical logistics.[27] Patients from cultures different from those of their physicians may have worse experiences with the delivery of bad news. In one study, nonwhite patients who had advanced AIDS rated the quality of patient-physician communication about end-of-life care lower than white patients with advanced AIDS.[28] It may be particularly important for physicians to openly address cross-cultural differences in patients' preferences about the delivery of bad news.

In some cultures, even articulating bad news may be associated with adverse consequences. In a qualitative study of Navajos, Carrese and Rhodes describe how the Navajo concept of *hozho* ("harmony") influences communication; patients and providers should think and speak in a positive way and avoid thinking or speaking in a negative way, which could constitute a dangerous violation of values.[29] This view may be more widespread than many realize. In a study of patients with advanced AIDS, Curtis and associates showed that African Americans with AIDS were more likely than white patients with AIDS to believe that discussing death could bring death closer.[15]

These findings indicate that physicians must be alert for situations in which their cultural beliefs and values may differ from those of their patients. In situations where cultural beliefs may differ widely, the questions in the Box can be used to develop a common understanding.[30]

Exploring cultural beliefs in discussing bad news*

- What do you think might be going on? What do you call the problem
- What do you think has caused the problem?
- What do you think will happen with this illness?
- What do you fear most with this illness?
- If we needed to discuss a serious medical issue, how would you and your family want to handle it?
- Would you [addressing patient] want to handle the information and decision making, or should that be done by someone else in the family?

*Modified from Kleinman et al[29]

The physician began by asking Ms Roberts how she was doing and what thoughts she had about the needle biopsy. Ms Roberts appeared nervous, so the physician addressed her anxiety by asking what she was most worried about. The patient expressed concern that a diagnosis of cancer would seriously affect her sister and husband. The physician then asked Ms Roberts if she was ready to go on, and after hearing "yes," told her that the needle biopsy confirmed the diagnosis of cancer of the liver. Ms Roberts was upset and tearful, but after a short time of quiet emotional support, the physician went on to discuss the next steps: a consultation with an oncologist, treatment of pain, treatment of anxiety, help talking with Ms Roberts' husband and sister, and consultation with a social worker about applying for disability.

CONCLUSION

Communicating bad news is a fundamental physician skill. Physicians should be aware that their own sense of what constitutes a good encounter may differ from that of many patients, especially when cultural backgrounds differ. These conversations, when handled well, can help patients feel informed and hopeful and physicians feel affirmed in their commitment to care for patients.

See this article on our web site for the complete list of references

Irritable bowel syndrome (IBS)

What is the cause of IBS?
How common is it?
Are there risk factors?
How do you make the diagnosis?
What treatments work?

Learn the answers to these questions and more in an evidence-based case review by Richard Birrer that is available online at www.ewjm.com. See this announcement on our web site for a link to the full article.